FISCAL INTERMEDIARY ACCESS TO MEDS ELIGIBILITY (FAME) DATA ELEMENT DESCRIPTIONS

NAME: **SEGMENT ID**

SOURCE: FAME LENGTH: 2

DEFINITION:

A two-digit field to identify the information in the fields following. FAME on-line is stored in a compressed format.

Segment Values:

- 01 Header information. There is always a segment 01.
- 10 Current month (MEDS RENEWAL MONTH)
- 11 First Prior month
- 12 Second Prior month
- 13 Third Prior month
- 14 Fourth Prior month
- 15 Fifth Prior month
- 16 Sixth Prior month
- 17 Seventh Prior month
- 18 Eighth Prior month
- 19 Ninth Prior month
- 20 Tenth Prior month
- 21 Eleventh Prior month
- 22 Twelfth Prior month
- 23 Thirteenth Prior month
- 24 Fourteenth Prior month
- 25 Fifteenth Prior month

SPECIAL CONSIDERATIONS:

The segment ids for the history months are defined by their relationship to the MEDS RENEWAL DATE. Current Month segment is always the MEDS RENEWAL Date Month and Year.

FISCAL INTERMEDIARY ACCESS TO MEDS ELIGIBILITY (FAME) DATA ELEMENT DESCRIPTIONS

NAME: **MEDS ID**

AKA: MEDS Identification Number

SOURCE: MEDS, COUNTY, SDX LENGTH: 9

DEFINITION:

A nine-digit number that is the primary and unique recipient identifier used by MEDS. The recipient's SSN is used when known to MEDS. If the SSN is unavailable, MEDS assigns a pseudo number beginning with the number 8 or 9 and ending with the letter 'P'.

FISCAL INTERMEDIARY ACCESS TO MEDS ELIGIBILITY (FAME) DATA ELEMENT DESCRIPTIONS

NAME: **MEDS ID CHECK DIGIT**

SOURCE: MEDS LENGTH: 1

DEFINITION:

A math formula generated digit that is used to verify the data entry of the MEDSID.

FISCAL INTERMEDIARY ACCESS TO MEDS ELIGIBILITY (FAME) DATA ELEMENT DESCRIPTIONS

NAME: **COUNTY-ID**

AKA: County Identification Number

SOURCE: COUNTY, Healthy Families,SDX LENGTH: 14

DEFINITION:

A fourteen position unique recipient identifier which has several formats:

County Welfare Department format:

FIELD NAME	*LENGTH*
County Code	2
Aid Code	2
Serial Number	7
FBU	1
Person Number	2 (distinguishes an individual)

SDX format:

FIELD NAME	*LENGTH*
County Code	2
Aid Code	2
Place holder	1 (Value '9')
SSN	9

Healthy Families format:

FIELD NAME	*LENGTH*
County Code	2
Aid Code	2
Place holder	1 (Value '9')
CIN	9

Values: See individual data element descriptions for county and aid code

FISCAL INTERMEDIARY ACCESS TO MEDS ELIGIBILITY (FAME) DATA ELEMENT DESCRIPTIONS

NAME: **CLIENT INDEX NUMBER (CIN)**

SOURCE: Daily MEDS Update Program LENGTH: 9

DEFINITION:

A permanent and unique CIN is assigned to every Health Services recipient via the daily MEDS batch update process. The one exception being for those cases represented by skeleton records. Once assigned, the CIN never changes. Even when a later change is made to the MEDS-ID (from Pseudo to SSN).

In addition to updating the MEDS data base, the new CIN and their corresponding MEDS-IDs must be written to a transaction file for updating the CIN Master file. The Client Index Master file is an IBM VSAM file with a primary index on Client Index Number and an alternate index on MEDS-ID number. The primary purpose of the Client Index Master file is for cross-referencing these two fields.

VALUES:

The Client Index Number is a nine character number. The first character is a predefined digit. The next seven characters are sequentially assigned numbers. The last character is a letter taken from a selected group of valid letters. Currently, the proposed list of legal letters for the terminal characters are:

ABCDEFGHMNSTUVWX.

SPECIAL CONSIDERATIONS:

When MEDS records are combined, the Master Index file always points to the MEDS-ID associated with the most current CIN. The older CIN entry becomes frozen.

NAME: **CIN CHECK DIGIT**

SOURCE: MEDS LENGTH: 1

DEFINITION:

A math formula generated digit that is used to verify the data entry of the Client Index Number (CIN).

NAME: **CA DRIVER'S LICENSE**

AKA: IDENTIFICATION NUMBER

SOURCE: N/A LENGTH: 8

DEFINITION:

FOR FUTURE USE.

NAME: **RECIPIENT NAME**

SOURCE: COUNTY, SDX, HF LENGTH: See below

DEFINITION:

The recipient name consists of three separate fields:

FIELD NAME	LENGTH
Last Name	20
First Name	15
Middle Initial	1

FISCAL INTERMEDIARY ACCESS TO MEDS ELIGIBILITY (FAME) DATA ELEMENT DESCRIPTIONS

NAME: **BIRTHDATE**

SOURCE: COUNTY, SDX, HF LENGTH: 8

DEFINITION:

BIRTHDATE represents the recipient's date of birth or for unborn recipients (SEX=U) the expected delivery date.

VALUES:

YYYY - YEAR
MM - MONTH
DD - DAY

NAME: **SEX**

SOURCE: COUNTY, SDX, MEDS, HF LENGTH: 1

DEFINITION:

This code identifies the sex of the recipient.

VALUES:

F Female
M Male
U Unborn

SPECIAL CONSIDERATIONS:

The only valid values for input by counties are ‘F’, ‘M’ and ‘U’.

When SEX is unborn (U), the BIRTHDATE is the expected delivery date. Medi-Cal ID cards cannot be issued for unborn recipients.

FISCAL INTERMEDIARY ACCESS TO MEDS ELIGIBILITY (FAME) DATA ELEMENT DESCRIPTIONS

NAME: **CARD ISSUE DATE**

SOURCE: MEDS LENGTH: 8

DEFINITION:

Represents the date of the recipient's most recently issued beneficiary identification card (BIC).

VALUES:

YYYY - YEAR
MM - MONTH
DD - DAY

FISCAL INTERMEDIARY ACCESS TO MEDS ELIGIBILITY (FAME) DATA ELEMENT DESCRIPTIONS

NAME: **CHAINED MEDS-ID**

AKA: CHAINED-ID

SOURCE: MEDS LENGTH: 9

DEFINITION:

A nine-digit number that is used in consolidating recipient eligibility information when more than one record has been established on MEDS for the same person. The CHAINED MEDS-ID is used to consolidate the eligibility history from multiple records, through a series of linkages, and tie this eligibility to one record that contains the recipient’s correct MEDS-ID and is used for future eligibility updates.

The CHAINED MEDS-ID field will contain a MEDS assigned pseudo number beginning with the number 8 or 9 and ending with the letter 'P'. Each record or link in the chain will contain a different CHAINED MEDS-ID that points to the MEDS-ID of the next record in the chain. To determine a recipient’s eligibility status for any given month, the Medi-Cal Fiscal Intermediary uses the CHAINED MEDS-ID fields to scan each linked record until positive eligibility is found.

NAME: **PRIOR MEDS-ID**

SOURCE: County LENGTH: 9

DEFINITION:

After the current MEDS-ID, prior MEDS-ID is the most recent MEDS-ID used to identify the recipient on MEDS.

VALUES:

Refer to MEDS-ID.

SPECIAL CONSIDERATIONS:

If the MEDS-ID was not originally reported, a pseudo MEDS-ID is assigned. If the recipient’s valid SSN is submitted later as the new MEDS-ID, the pseudo MEDS-ID is maintained as the prior MEDS-ID.

FISCAL INTERMEDIARY ACCESS TO MEDS ELIGIBILITY (FAME) DATA ELEMENT DESCRIPTIONS

NAME: **ALIEN INDICATOR**

SOURCE: SDX, COUNTY LENGTH: 1

DEFINITION:

This code indicates whether an individual is a refugee, in a special alien status category or is a U.S. citizen. The information is used, among others, for the refugee and qualified and not qualified alien tracking systems.

VALUES:

See 'REFUGEE/ALIEN' on MEDS QUICK REFERENCE SHEET for values.

SPECIAL CONSIDERATIONS:

The values 0, 1, 7 and 9 became obsolete December 1998. The value 0 had been requested by counties to identify aliens who did not fall into any other categories. Since the values have been expanded and changed, the new values will accommodate the various groups of aliens previously reported using 0. Counties requested a full set of new values so they could easily tell whether or not a client’s refugee/alien status had been reevaluated. The values 1 and 7 have previously been used to identify Conditional Entrants, Asylees, Indochinese and other Refugees, Parolees, and Ameriasians. These various groups of aliens have now been given more specific indicators in order to identify them for the refugee DED NO. 2009 program and as Qualified and Not Qualified Aliens. The value 9 was previously used to identify aliens who were over 65 but not eligible for Medicare because they had not met their five-year residency requirement. The Medicare Buy-In unit is able to continue to suppress the potential Medicare Buy-In alert message issued by MEDS renewal by using the date of entry of the alien and the date of birth.

NAME: **ETHNIC CODE**

SOURCE: COUNTY, SDX, HF LENGTH: 1

DEFINITION:

This code indicates the ethnic group the applicant represents in the opinion of the eligibility interviewer.

VALUES:

See 'ETHNIC' on MEDS QUICK REFERENCE SHEET for appropriate values and definitions.

SPECIAL CONSIDERATIONS:

The code of '8' is generated by MEDS when an invalid code is submitted.

NAME: **LANGUAGE CODE**

SOURCE: COUNTY, HF LENGTH: 1

DEFINITION:

The recipient's primary language.

VALUES:

See 'LANGUAGE' on MEDS QUICK REFERENCE SHEET for appropriate values and definitions.

SPECIAL CONSIDERATIONS:

The code of '8' is generated by MEDS when an invalid code is submitted.

FISCAL INTERMEDIARY ACCESS TO MEDS ELIGIBILITY (FAME) DATA ELEMENT DESCRIPTIONS

NAME: **HEALTH INSURANCE CLAIM NUMBER (HIC NO.)**

SOURCE: COUNTY, BENDEX, BUY-IN LENGTH: 12

DEFINITION:

This is the claim number the recipient uses for claiming Medicare, Buy-In or Railroad Retirement benefits.

VALUES:

The HIC contains a nine-digit number plus a suffix of one to three characters. If the letter 'H' appears in the first position of a HIC suffix (i.e., HA, HB, HC1), it indicates the claimant is being paid through the SSA disability program. However, the 'H' is not recorded on the tape from Baltimore.

Some Railroad Retirement Board (RRB) numbers consist of a prefix of one to three characters and a six-digit number issued by the Railroad Retirement Board. Other RRB numbers consist of a prefix of one to three characters and the annuitant's SSN. RRB numbers should be reported as follows:

CA 123456
A 123456789

SPECIAL CONSIDERATIONS:

A county may not update this element after the state has bought into the Medicare for the recipient benefits (MEDICARE = 02 or 03).

NAME: **DEATH DATE**

SOURCE: MEDS, DHS, SDX, VITAL STATISTICS LENGTH: 8

DEFINITION:

This field represents the date a recipient became deceased. This information currently comes from one of three sources: 1) a Medi-Cal ID Card for an SSI/SSP recipient marked deceased and returned to DHS by the Post Office; 2) an SDX update with a payment status code indicating that the recipient is deceased; or 3) a Pickle status update indicating that the recipient is deceased. When death information comes from an SDX update, the date of death from SDX will be in the death date field. When death information comes from a returned ID card, the death date field will contain the date on which the returned card information updated MEDS and the termination date (TERM-DT) is changed to the end of the month prior to the valid month and year of the ID Card that was returned. When death information comes from a Pickle update, the death date field will contain the date on which the Pickle transaction updated MEDS.

VALUES:

YYYY - YEAR
MM - MONTH
DD - DAY

SPECIAL CONSIDERATIONS:

MEDS uses the death information to verify that an individual has not been reported as deceased before accepting a request to issue an ID card.

NAME: **DEATH DATE POSTED TO MEDS**

SOURCE: MEDS LENGTH: 8

DEFINITION:

This field is present when MEDS has received information indicating that the recipient is deceased, and indicates the date that the death date was posted on MEDS.

VALUES:

YYYY - YEAR
MM - MONTH
DD - DAY

NAME: **MEDS RENEWAL DATE**

SOURCE: MEDS LENGTH: 6

DEFINITION:

This date indicates which calendar month the MEDS current month information represents.

VALUES:

YYYY - YEAR
MM - MONTH

SPECIAL CONSIDERATIONS:

The monthly MEDS renewal cycle rolls the MEDS calendar to the next month. The MEDS renewal is processed before the end of a month so that the MEDS RENEWAL DATE is a future month date for the last days of a calendar month. For example, on March 29, 1996 the MEDS RENEWAL DATE could be 041996 (April would be the current MEDS month) and March 1996 would be the first prior month.

NAME: **LAST MODIFIED DATE**

SOURCE: FAME LENGTH: 8

DEFINITION:

Indicates the last date a change was applied to the FAME record of a Medi-Cal recipient.

VALUES:

YYYY - YEAR
MM - MONTH
DD - DAY

NAME: **PAPER CARD ISSUE DATE**

SOURCE: MEDS LENGTH: 8

DEFINITION:

Represents the date of the recipient's most recent issued paper beneficiary identification card (BIC). Paper cards are generally printed for immediate need purposes only.

VALUES:

YYYY - YEAR
MM - MONTH
DD - DAY

FISCAL INTERMEDIARY ACCESS TO MEDS ELIGIBILITY (FAME) DATA ELEMENT DESCRIPTIONS

NAME: **CMS INDICATOR**

SOURCE: CMS-Net, GHPP LENGTH: 1

DEFINITION:

This indicates if the client has ever been known to either Children's Medical Services (CCS) or Genetically Handicapped Persons Program (GHPP) or both.

VALUES:

space	-	Not known to CCS or GHPP
zero	-	Not Known to CCS or GHPP
1	-	Known to CCS
2	-	Known to GHPP
3	-	Known to CCS and GHPP

FISCAL INTERMEDIARY ACCESS TO MEDS ELIGIBILITY (FAME) DATA ELEMENT DESCRIPTIONS

NAME: **CURRENT MONTH DATA**

SOURCE: MEDS LENGTH: 82 (POSITIONS 189-270)

DEFINITION:

Recipient eligibility information that pertains to the current MEDS month reflected in the MEDS RENEWAL DATE FIELD. The following data elements appear within the eligibility segment:

FIELD NAME	LENGTH	POSITION
SEGMENT ID	2	189-190
COUNTY CODE	2	191-192
PRIMARY AID CODE	2	193-194
PRIMARY ESC	3	195-197
1ST SPECIAL AID CODE	2	198-199
1ST SPECIAL ESC	3	200-202
2ND SPECIAL AID CODE	2	203-204
2ND SPECIAL ESC	3	205-207
3RD SPECIAL AID CODE	2	208-209
3RD SPECIAL ESC	3	210-212
SOC AMOUNT	5	213-217
SOC CERT DAY	2	218-219
PERCENTAGE OBLIGATED	2	220-221
OTHER HEALTH CODE	1	222-222
MEDICARE STATUS CODE	2	223-224
RESTRICT SERVICE CODE	3	225-227
MULTI-SOC-CASE ID	2	228-229
1ST HCP CODE	3	230-232
1ST HCP STATUS	2	233-234
2ND HCP CODE	3	235-237
2ND HCP STATUS	2	238-239
3RD HCP CODE	3	240-242
3RD HCP STATUS	2	243-244
4RD HCP CODE	3	245-247
4RD HCP STATUS	2	248-249
5TH HCP CODE	3	250-252
5TH HCP STATUS	2	253-254
STATE/FEDERAL INDICATOR	1	255-255
HF IN DAY	2	256-257
HF OUT DAY	2	258-259
FILLER	11	260-270

SPECIAL CONSIDERATIONS:
The data fields in positions 189 - 270 repeat for the FIFTEEN history months prior to the current MEDS RENEWAL DATE. The data in these fields is applicable to the history month under which it is reported. The history months are defined by their relationship to the MEDS RENEWAL DATE. The first prior segment represents the history month prior to the MEDS RENEWAL MONTH. For example, if MEDS current month is March 1998, the first prior month is February 1998; second prior month is January 1998, third prior month is December 1997, etc.

FISCAL INTERMEDIARY ACCESS TO MEDS ELIGIBILITY (FAME) DATA ELEMENT DESCRIPTIONS

NAME: **COUNTY**

AKA: County of Responsibility

SOURCE: COUNTY, SDX, HF LENGTH: 2

DEFINITION:

The numeric code of the county. This can be the responsible county for Medi-Cal eligibility. Listed is universal set of county codes used by the State and Counties to identify the California county codes. Valid values are 01 through 58.

VALUES:

01	Alameda	30	Orange
02	Alpine	31	Placer
03	Amador	32	Plumas
04	Butte	33	Riverside
05	Calaveras	34	Sacramento
06	Colusa	35	San Benito
07	Contra Costa	36	San Bernardino
08	Del Norte	37	San Diego
09	El Dorado	38	San Francisco
10	Fresno	39	San Joaquin
11	Glenn	40	San Luis Obispo
12	Humboldt	41	San Mateo
13	Imperial	42	Santa Barbara
14	Inyo	43	Santa Clara
15	Kern	44	Santa Cruz
16	Kings	45	Shasta
17	Lake	46	Sierra
18	Lassen	47	Siskiyou
19	Los Angeles	48	Solano
20	Madera	49	Sonoma
21	Marin	50	Stanislaus
22	Mariposa	51	Sutter
23	Mendocino	52	Tehama
24	Merced	53	Trinity
25	Modoc	54	Tulare
26	Mono	55	Tuolumne
27	Monterey	56	Ventura
28	Napa	57	Yolo
29	Nevada	58	Yuba

NAME: **PRIMARY AID CODE**

SOURCE: COUNTY, SDX, HF LENGTH: 2

DEFINITION:

The two-character identifier that indicates the primary aid category a Medi-Cal recipient is eligible under.

FISCAL INTERMEDIARY ACCESS TO MEDS ELIGIBILITY (FAME) DATA ELEMENT DESCRIPTIONS

NAME: **PRIMARY ELIGIBILITY STATUS CODE (ESC)**

SOURCE: MEDS LENGTH: 3

DEFINITION:

A three position code which reflects Medi-Cal eligibility status information in the first digit, normal/exception eligibility information in the second digit, and information regarding the type of timeliness of reporting of the eligibility status in the third digit. This ESC field represents eligibility for the Primary Aid Code.

VALUES:

1st DIGIT -- Medi-Cal/CMSP/Other Eligible Status

See 'ELIG' on MEDS QUICK REFERENCE SHEET for appropriate values and definitions.

2nd DIGIT -- Normal/Exception Eligibility

See 'ELIG' on MEDS QUICK REFERENCE SHEET for appropriate values and definitions.

3rd DIGIT -- Timeliness/Misc. Information

See 'ELIG' on MEDS QUICK REFERENCE SHEET for appropriate values and definitions.

FISCAL INTERMEDIARY ACCESS TO MEDS ELIGIBILITY (FAME) DATA ELEMENT DESCRIPTIONS

NAME: **SPECIAL AID CODE (1-3)**

AKA: Special Program Aid Code

SOURCE: COUNTY, HF LENGTH: 2

DEFINITION:

A two digit number that identifies under which aid category a Medi-Cal recipient is eligible.

NAME: **SPECIAL ESC (1-3)**

AKA: SPECIAL PROGRAM ELIGIBILITY STATUS CODE

SOURCE: MEDS LENGTH: 3

DEFINITION:

A three position code which reflects Medi-Cal/CMSP/Other Eligibility status in the first digit, Normal/Exceptional Eligibility status in the second digit, and Timeliness/Miscellaneous Information in the third digit. A separate Special ESC will be displayed for each Special Aid Code.

VALUES:

See Definition for PRIMARY ELIGIBILITY STATUS CODE.

NAME: **SOC AMOUNT**

AKA: Share of Cost Amount

SOURCE: COUNTY, DHS LENGTH: 5

DEFINITION:

Before certain recipients become certified Medi-Cal eligibles, they are obligated to meet a share of their medical costs. This field represents the share of cost amount the recipient is obligated to meet.

NAME: **CERT-DAY**

AKA: Share of Cost Certification Day

SOURCE: COUNTY, POS NETWORK LENGTH: 2

DEFINITION:

This is the day of the month that recipient's share of cost amount was met. This is also the day of the month the recipient becomes a certified Medi-Cal eligible.

VALUES:

DD - Valid day in the month.

NAME: **PERCENT OBLIGATION**

AKA: % Oblig

SOURCE: COUNTY LENGTH: 2

DEFINITION:

Percentage of the costs that TPN/Dialysis clients owe for each service covered under the TPN/Dialysis program.

VALUES:

NAME: **OTHER-COVERAGE**

AKA: Other Health Coverage

SOURCE: COUNTY, SDX, DHS, HF LENGTH: 1

DEFINITION:

This code identifies a recipient's private health care coverage by a health care insurance company, a Prepaid Health Plan (PHP), or a Health Maintenance Organization (HMO). It indicates that health care services should, in most cases be covered by the private health care coverage instead of by Medi-Cal.

VALUES:

See 'OHC-OTH-COV' on MEDS QUICK REFERENCE SHEET for appropriate values and definitions.

NAME: **MEDICARE CODE**

AKA: Medicare Status

SOURCE: BUY-IN, SSA LENGTH: 2

DEFINITION:

This two digit code reflects a recipient's Medicare Part A (Inpatient) and Part B (Medical) entitlement status.

VALUES:

See 'MEDICARE' on MEDS QUICK REFERENCE SHEET for appropriate values and definitions.

NAME: **RESTRICTION SERVICES CODE**

AKA: Restricted Services Code

SOURCE: COUNTY, DHS LENGTH: 3

DEFINITION:

A three position code that reflects restrictions placed upon the Medi-Cal services to which a recipient is entitled.

VALUES:

See 'RESTRICT' on MEDS QUICK REFERENCE SHEET for appropriate values and definitions.

NAME: **MULTIPLE SHARE OF COST (SOC) INDICATOR**

SOURCE: MEDS LENGTH: 2

DEFINITION:

This indicator identifies a person who is an ineligible member or responsible relative in a Share of Cost (SOC) case.

VALUES:

IE - Ineligible - A family member who is ineligible for Medi-Cal benefits in the case. An IE person may only use unreimbursed medical expenses to meet the SOC for other family members associated within the same budget unit (BU). Upon certification of the SOC, the IE individual is not eligible for Medi-Cal benefits in this case. An IE person may be eligible for Medi-Cal benefits in another BU where the person is not identified as IE.

RR - Responsible Relative - A family member who is ineligible for Medi-Cal benefits in the case. An RR person may only use unreimbursed medical expenses to meet the SOC for other family members associated within the same budget unit (BU). Upon certification of the SOC, the RR individual is not eligible for Medi-Cal benefits in this case. An RR person may be eligible for Medi-Cal benefits in another BU where the person is not identified as RR.

FISCAL INTERMEDIARY ACCESS TO MEDS ELIGIBILITY (FAME) DATA ELEMENT DESCRIPTIONS

NAME: **Health Care Plan (HCP) CODE (1-5)**

SOURCE: MEDS, HCPs, HCO Contrator LENGTH: 3

DEFINITION:

The HCP code (also known as Plan Code, Project Code, or MCP code) is a three-digit code that identifies the Medi-Cal managed care plan(s) in which a recipient has been enrolled or disenrolled. MEDS has the capability to enroll a recipient in up to five separate plan codes at one time.

SPECIAL CONSIDERATIONS:

The second through fifth HCPs are for non-medical coverage.

NAME: **Health Care Plan (HCP) STATUS (1-5)**

SOURCE: MEDS LENGTH: 2

DEFINITION:

This code identifies the status of a recipient's enrollment in an associated HCP code.

VALUES:

blank	Disenrollment occurred in prior month - no capitation paid
00	Voluntary disenrollment - no capitation paid (May also result from the retroactive disenrollment of a recipient in hold status - no capitation recovery)
01	Active enrollment - capitation paid
05	Enrollment held due to recipient's Medi-Cal eligibility status - no capitation paid
09	Mandatory disenrollment - no capitation paid. (May also result from the retroactive disenrollment of a recipient in hold status - no capitation recovery)
10	Voluntary disenrollment after capitation paid - recovery required. (The result of a retroactive disenrollment from an active HCP status)
19	Mandatory disenrollment after capitation paid - recovery required. (The result of a retroactive disenrollment from an active HCP status)
40	Voluntary disenrollment occurred before enrollment became effective - no capitation paid (very rare, but possible)

NAME: **Health Care Plan (HCP) STATUS (1-5) (Continued)**

VALUES:

49	Mandatory disenrollment occurred before enrollment became effective - no capitation paid (very rare, but possible)
51	Enrollment activated from hold status - supplemental capitation to be paid at the end of the current month
55	Enrollment held - Potential HCP enrollee with Uncertified SOC - no capitation paid
59	Enrollment held due to change of recipient's status other than hold on Medi-Cal eligibility (e.g. zip code, county code, aid code or ohc code not covered by plan) - no capitation paid
P4	Enrollment application accepted - no capitation paid
S0	Voluntary disenrollment after capitation paid - recovery processed (The result of a retroactive disenrollment from an active MCP status)
S1	Active enrollment - supplemental capitation paid for individual release from hold status
S9	Mandatory disenrollment after capitation paid - recovery processed (The result of a retroactive disenrollment from an active MCP status)

SPECIAL CONSIDERATIONS:

A separate HCP status will be displayed for each HCP code. The second through fifth HCPs are for non-medical coverage.

A 'blank' HCP status occurs after the month in which a disenrollment has become effective. A 'blank' HCP status code should ALWAYS be preceded by a HCP status code of '00', '09', 'S9', 'S0', '40', '49'. (COHS plans excluded).

HCP-STATUS codes '05' and '55' are updated to '51' when Medi-Cal eligibility is reinstated or SOC has been certified. The ‘05’ status may not appear in a history month on the HCP FAME file.

HCP-STATUS '51' is updated to 'S1' when the MEDS monthly renewal process initiates payment of the capitation. HCP-STATUS '19' is updated to 'S9' and HCP-STATUS '10' is updated to 'S0' after the MEDS monthly renewal process initiates the recovery process.

After two consecutive months of a HCP hold status of '05', *'55'* or '59', MEDS renewal terminates the MCP enrollment effective the following month resulting in HCP-STATUS '09'.

FISCAL INTERMEDIARY ACCESS TO MEDS ELIGIBILITY (FAME) DATA ELEMENT DESCRIPTIONS

NAME: **STATE/FEDERAL INDICATOR**

SOURCE: LENGTH: 1

DEFINITION:

FUTURE USE

NAME: **HEALTHY FAMILIES IN DAY**

SOURCE: HF LENGTH: 2

DEFINITION:

This day identifies the start day of Healthy Families when the client is not enrolled for the entire month. For example, if the client had been enrolled on the first day of the month, no day would appear in this field since the client is enrolled for the entire month. This field is used in conjunction with the Special Program eligibility aid code and status for HF in the segment.

VALUES:

Valid day or spaces.

NAME: **HEALTHY FAMILIES OUT DAY**

SOURCE: HF LENGTH: 2

DEFINITION:

This day identifies the stop day of Healthy Families when the client is not enrolled for the entire month. For example, if the client had been terminated on the last day of the month, no day would appear in this field since the client is enrolled for the entire month. This field is used in conjunction with the Special Program eligibility aid code and status for HF in the segment.

VALUES:

Valid day or spaces.